477-000-014 – Resource Provisions

The Specified maximum for funds set aside for burial increases by the Consumer Price Index every September.

Burial Trust Limit	Effective Date
$4,916	September 1, 2014
$4,834	September 1, 2013
$4,762	September 1, 2012
$4,683	September 1, 2011
$4,513	September 1, 2010
$4,462	September 1, 2009
$4,462	September 1, 2008
$4,235	September 1, 2007
$4,153	September 1, 2006

Effective 2012 the specified home equity value is $536,000. For those who apply January 1, 2006, or later, the home equity value provision applies to the initial determination and redeterminations for long-term care services.

477-000-015 – Third Party Liability

Refer all questions regarding third party payments received directly to DHHS.MedicaidCasualty.nebraska.gov.

477-000-016 – Health Insurance Premium Payment (HIPP) Program

Nebraska will pay the health insurance premium for Medicaid eligible clients in cases where it is cost-effective for the state. Payment of this premium does not replace Medicaid coverage. Instead, a third party (insurance company) would be the primary payer on claims and Medicaid would be secondary.

Workers should refer new or existing cases if the individual is Medicaid eligible, has health insurance, expects high medical expenses, and cannot afford to continue paying his or her health insurance premium.

Examples of Medical Conditions Generally Considered Cost-Effective for the State

- Cancer (currently receiving chemotherapy or radiation)
- Pregnancy
- AIDS
- Infants born prematurely or with a serious medical condition
- Renal failure
- Upcoming surgery
- Any condition requiring hospitalization
- Any life-threatening illness
- An accident causing serious injury

This list is not comprehensive. There are many other conditions that could be considered cost-effective.

Examples in which HIPP Program will Not Pay Health Insurance Premium

- The individual is aged
- The individual needs to pay his or her health insurance premium to stay Medicaid eligible (i.e., he or she needs the insurance as a deduction in their budget)
- The individual is eligible for Medicare
- The premium is for TMA
- The insurance policy is a CHIPS policy
- The individual's share of cost obligation is higher than the monthly premium
- There is a court-issued medical support order that pays for the insurance policy

Note: When HIPP pays an individual's health insurance premium, it may **not** be counted as a deduction in the budget. Please determine the impact of HIPP paying an individual's insurance premium on the person's budget before making a referral to the HIPP program.

HIPP referrals should be made to:

- DHHS Medicaid and Long-Term Care
  HIPP Program
  P.O. Box 95026
  Lincoln, NE 68509;
- DHHS.MedicaidHIPP@nebraska.gov

477-000-026 – Basic Budgetary Allowance for Non-MAGI

Medical Deductions: Verify medical insurance policies and document the following:

1. Name and address of insurance company;
2. Type of coverage;
3. Policy number;
4. Premium amount;
5. Effective dates of coverage; and
6. Policy owner and individual(s) covered.

Primary Sources

a. The insurance policy;
b. Contact with the insurance company;
c. Premium notice;
d. Contact with the employer;
e. Blue Cross Blue Shield TPL alert (the premium amount cannot be verified with this alert if it is employer sponsored health insurance);
f. Contact with the policy owner, if other than the client; or
g. Cancelled checks for health insurance premiums.

477-000-028 – Amounts Used for Budgeting Non-MAGI Couples (SIMP)

AMOUNTS USED FOR BUDGETING COUPLES (Effective 1-1-2015)	
The following figures are used on side 2 of Form DA-4M	
Income level (based on 150% of Federal Poverty Level for Two)	$1,967
Excess shelter limit	$590
Utility standard	$434
Maximum maintenance allowance for ineligible spouse	$2,981

477-000-029 – Calculation of Resources Reserved for Community Spouse

The assessment of resources is based on the value of resources owned during the month the alternate care spouse enters the specified living arrangement.

$ 23,844 is the minimum amount.
$119,220 is the maximum amount.
$238,440 is twice the maximum amount.

The community spouse is entitled to reserve the greater of:

1. One-half of the combined equity value of all countable resources not to exceed $119,220 (the maximum amount); or
2. $23,844 in equity value of countable resources (the minimum amount).

Previous Minimum and Maximum Amounts		
Year	**Minimum**	**Maximum**
2014	$23,448	$117,240
2013	$23,184	$115,920
2012	$22,728	$113,640
2011	$21,912	$109,560
2010	$21,912	$109,560
2009	$21,912	$109,560
2008	$20,880	$104,400
2007	$20,328	$101,640
2006	$19,908	$99,540
2005	19,020	95,100
2004	18,552	92,760

477-000-031 – Real Property Sold on Contract

When real property is sold on contract rather than an outright full purchase, certain conditions of the contract must be met to verify adequate compensation and to avoid applicable deprivation of resources policy. These conditions are:

1. Current fair market value must be used for the sale/purchase agreement.
2. The contract period must not exceed the life expectancy of the participant. (See Life Expectancy Table and Deprivation of Resources reference.)
3. The contract must not include balloon payments. (See Deprivation of Resources reference regarding equal payments.)
4. Appropriate default language for recovery upon failure to make scheduled payment.
5. Contract balance/scheduled payments cannot be forgiven during the life of the contract, i.e., no exculpatory or cancellation terms.
6. Appropriate interest rate on unpaid balance.
7. Payments must commence immediately.
8. Amortization schedule to demonstrate #2, #6, and #7.

These are general guidelines that are used to verify adequate compensation to the participant for the contract sale. Central Office Public Assistance staff may assist the Local Office in making the determination.

477-000-032 – Deprivation of Resources

Example 1:
Mr. Smith applies for Medicaid on 8/20/10. He has been in a Nursing Home since 6/06. On 3/15/09 he gave $30,000 to his son. The transfer is within the 60-month period prior to the date of his Medicaid application and the penalty begins with the date of application which is 8/20/10. A denial Notice of Action will need to be sent for deprivation of resources stating the penalty period is 6.19 months. For a notice type, you will need to select "transfer of assets" under sanctions.

$30,000 amount of transfer
- 4,000 allowable resource level
$26,000 ÷ $4,200 current private pay rate = 6.19 number of months for penalty period

Example 2:
Mr. Smith transferred his ranch with fair market value of $250,000 to his children on 3/15/08. He permanently entered a nursing home on 11/10/10. Mr. Smith applies for Medicaid on 5/14/11 which is within the 60-month period prior to the date of transfer. He is ineligible for 51.25 months beginning with 5/11.

Step A
$250,000 amount of transfer
- 4,000 allowable resource level
$246,000 ÷ $4,800 current private pay rate = 51.25 number of months penalty period

Mr. Smith reapplies for Medicaid in the month a partial penalty of .25 applies. The partial month penalty is converted to a dollar amount and applied to the Share of Cost for that month.

Step B
$4,800 private pay cost
x 51 fifty one month penalty period
$244,800 penalty period amount for 51 full months

Step C
$246,000 transfer amount
-244,800 penalty period amount for 51 full months
$1,200 partial month penalty amount at private pay rate

For the month of application, the partial month penalty amount of $1,200 would be added to Mr. Smith's Share of Cost amount as his responsibility for the cost of care. Medicaid will not pay the nursing home the difference between the Medicaid rate and partial month penalty amount.

Example 3:
Mr. Smith entered a nursing home on 12/1/2005, and applied for Medicaid on 6/25/11. On 2/25/09 he transferred a $20,000 CD to his son. On 12/10/09 he transferred a $10,000 CD to his grandchild. Since Mr. Smith is in a nursing home and has transferred resources for less than fair market value during the 60-month period before the date of his Medicaid application, he is subject to a period of ineligibility from the date of his application. Current actual monthly cost to a private pay patient is $5,000.

$20,000 amount of transfer on 2/25/09
- 4,000 allowable resource level
$16,000 countable disposal ÷ $5,000 private pay cost = 3.20 months of ineligibility

$10,000 amount of transfer on 12/10/09.
Do not allow the $4,000 resource level since this was allowed on the 2/25/09 transfer.
$10,000 ÷ $5,000 private pay cost = 2 months of ineligibility
Total months of ineligibility are 5.20 beginning with 6/11 the month of Medicaid application.

Example 4:
Mr. Smith lives at home and gave his son $12,000 on 3/25/11. Mr. Smith applied and was approved for Medicaid in 09-11. Deprivation regulations do not apply to current eligibility because he is not in a nursing home or receiving any type of nursing services.
On 10/2/11 Mr. Smith enters a nursing home and the monthly private pay rate is $4,800. A transfer of assets for less than fair market value has occurred within the 60-month look back period from the date of nursing home entry. Mr. Smith is ineligible for nursing home payment for a period of 1.67 months. Deprivation does not apply until Mr. Smith was residing in a specified living arrangement.

$12,000 amount of transfer on 3/25/11
- 4,000 allowable resource limit
$8,000 ÷ $4,800 private pay cost = 1.67 months of ineligibility from the month of entry to the nursing home (specified living arrangement).

Mr. Smith must be given ten-day notice that he is ineligible for 1.67 months effective 3/11 due to deprivation of resources. If the partial month penalty amount added to the Share of Cost amount exceeds the Medicaid per diem for the entire period, you will enter the private pay rate per diem on N-FOCUS. There will be no Medicaid payment to the nursing home and the penalty has been met.

Example 5:
Mr. Smith applies for Medicaid on 8/10/11 and has lived in the nursing home for several years. There were 4 transfers of cash made as follows:

In 3/11 he transferred $4,000 to his daughter
In 4/11 he transferred $3,500 to his daughter
In 5/11 he transferred $3,000 to his son
In 6/11 he transferred another $3,500 to his son

All the transfers are within the 60-month look back period. The total amount transferred is $14,000. The private pay rate at the nursing home is $4,600. The penalty periods are calculated as follows:

$14,000 cash transferred
-4,000 allowable resource level
$10,000 total countable disposal
$10,000. ÷ $4,600 private pay cost = .76 partial month of ineligibility
Total months of ineligibility are 2.17 beginning with 8/11, the month of Medicaid application.

Example 6:
Mr. Smith transferred his farm with a value of $300,000 to his son on 2/14/2010 by recorded deed. He applied for Medicaid on 9/2/0/11 and his current resources consist of a savings account with $5,000 and a money market account with a balance of $20,000. Mr. Smith wants to get a period of ineligibility started because of the deprivation. This is not possible because he is currently over the permitted resource limit of $4,000. A period of ineligibility may not begin until the applicant is eligible for Medicaid except for the deprivation of resources.

Example 7:
Mr. Smith transferred his house with a value of $485,000 to his daughter on 1/10/2006 by recorded deed. He applied for Medicaid on 9/15/2011 because he is out of funds to pay for his stay in the nursing home. There is no deprivation to consider because the transfers took place beyond the 60 month look back. Month one of the look back is the month prior to the month of application.

477-000-033 – Deprivation of Resources Hardship Waiver Procedure

For deprivation transactions 2/8/2006 or later, the following procedure will be followed for a Hardship Waiver:

a. The Notice of Action for Medicaid denial or closure because of existing period of ineligibility for deprivation of resources will include a statement of the individual's right to request a Hardship Waiver.
b. The Hardship Waiver written request must be submitted to the Local Office. The facility may file this request with the written consent of the individual or his/her legal representative.
c. The Local Office will then submit this request to Medicaid Policy Staff at Central Office with the following information attached:
    a. Living arrangement of the individual/spouse at time of transfer;
    b. Documentation of spouse and/or individual's current resources;
    c. Documentation of transferred resource dates, signatory(s)/requester (person signing or requesting the transfer), amounts, and relationship of individual to whom the resource was transferred;
    d. Copies of any informal or legal action already initiated to recover resources
d. If the client/spouse did **not** participate in the transfer, then Central Office will immediately notify the Local Office to open the case for 30 days/one month while the final decision on the Hardship Waiver is made.
    (1) This specific month will be determined in consultation with the worker. (Open for specified month and close for the following month.)
    (2) This will apply to nursing facility services (assisted living waiver, nursing home, acute care hospital, IMD).
    (3) If a Hardship Waiver decision cannot be made within the 30 days, then Central Office will notify the individual and Local Office that the decision remains pending.
        i. Note: If the client/spouse participated in the transfer, hardship will be denied. If it is demonstrated that the client/spouse had a guardian and/or conservator on the date of the client/spouse signature, then the signature of that client/spouse on a transfer action does not constitute participation and a fraud referral must be made.
    (4) Central Office will notify the Local Office of the Hardship Waiver decision.

1. Hardship Waiver **Denial**
    1. The client/representative may appeal the denial. Do not open the case for other than the notified 30 day/month temporary period if an appeal is filed.
2. Hardship Waiver **Approval**
    a. Local Office will open the case.
    b. Local Office will notify in comment section of the approval notice of action that the client is "required to immediately and continuously pursue recovery of the transferred resources, including, but not limited to, full cooperation with Adult Protective Services, Attorney General Fraud Unit, and any court proceedings. Failure to take action to recover or cooperate will immediately end Medicaid eligibility."

477-000-034 – Resource Spend Down

A client may reduce resources to the allowable limit and establish a medical effective date earlier than the month in which the resources are reduced if the excess resources are paid on outstanding medical bills incurred no earlier than the third month prior to the month of request. If the client reduces resources on outstanding medical bills, the medical effective date would be the first day of the month, retroactive or prospective, in which the last medical bill was paid which reduced the resources to the allowable limit.

Examples:

Excess Resources in Month of Application

Outstanding Medical Bills	Application	Resources Reduced
Jan 1-10, Feb 2, 5, 12, 25, Mar 1-31	March (excess resources)	April (below limit)

If medical bills for Jan 1-10 and Feb 2 and 5 were used to reduce resources, medical eligibility would begin Feb 1 even though the bills were not actually paid until April.
If resources were reduced in April on something other than the outstanding medical bills, e.g., purchase of a burial fund, medical eligibility would begin April 1.

Below Resource Limit in Month of Application

Outstanding Medical Bills		Application
Jan 3-15, 25, (excess resources)($500)	Feb 10, 18, 22, March 5, 8	April (below limit)

The client is eligible April 1 without a spenddown; however, if s/he wants medical eligibility established retroactively a resource spenddown must be done. Verify the resources in the oldest month in which there are outstanding medical bills, but no earlier than the third month prior to the month of request. In this situation the client has $500 excess resources in January.

If the client pays $500 on the medical bills and the last bill paid was incurred Feb 18, medical eligibility would begin Feb 1.

The client must pay the amount of the excess resources from January even though s/he is below resources in April.

Procedures:

1. Calculate the amount of excess resources in either the month of application or in a prior month if the client is below the resource limit in the month of application and there are outstanding medical bills.
2. Verify the dates and amounts of outstanding medical bills incurred within three months prior to the month of request for assistance.
3. Assist the client in identifying out-of-pocket medical costs which are to be paid by resource spenddown. If there is Medicare or private health insurance, you must have EOBs to determine out-of-pocket costs.
4. Obtain verification of paid medical bills used for resource spenddown. For any month there is Medicaid eligibility by payment of medical bills to reduce resources, there must be paid receipts for out-of-pocket medical expenses to verify the resource reduction.

5. If there is a monthly POS or Share of Cost, the amount of the resource reduction should be added to the POS or SOC amount.

    a. If there is no POS or Share of Cost, proof of out-of-pocket payment on medical bills is all that is needed.

    b. Example: Application for nursing home care made on 3/15 and resources are $4,450 at the time of application. Medical is being requested effective 2/1 as there are unpaid out-of-pocket pharmacy bills totaling $700. February's budget as a POS of $400 to which you would add $450 for the resource reduction. The total February POS would be $850 and the notice would state that $450 of the amount was to reduce resources.

    c. If this is a Share of Cost case, the first items on the Share of Cost form would be medical items paid to reduce the resource.

6. On the Notice of Action, state the amount of bills paid by the client from excess resources that are included in the Share of Cost amount or POS amount.

477-000-036 – Liquid/Non-Liquid Resources for Non-MAGI

Liquid Resources: Cash or other property that can be converted to cash within 20 days.

Examples of Liquid Resources:

1. Cash on hand;
2. Cash in savings or checking accounts;
3. Certificates of deposit;
4. Stocks;
5. Bonds;
6. Investments;
7. Mutual fund shares;
8. Collectable unpaid notes or loans;
9. Promissory notes;
10. Mortgages;
11. Land contracts;
12. Land leases;
13. Revocable burial funds;
14. Trust, guardianship or annuity funds;
15. Cash value of insurance policies;
16. Other similar properties; and
17. Medical savings accounts.

Excluded Liquid Resources:

Reverse Mortgage Monthly Income for AABD

Use the following method to determine counting or excluding monthly income from a reverse mortgage:

> Do not count the reverse mortgage as monthly income to the Medicaid client if the monthly income for the reverse mortgage is NOT funded through an annuity.
>
> Count reverse mortgage monthly income as unearned income to the Medicaid client if the monthly reverse mortgage income IS funded through an annuity. Annuity rules and not reverse mortgage rules apply in this instance. This does not need Central Office review.
>
> Always count reverse mortgage monthly income paid to a community spouse because they are not a Medicaid client and the Medicaid exclusions of counting income do not apply to the community spouse.

Medicare Set-Aside Arrangement (MSA)

Medicare takes the position of a secondary payer in cases where there is another culpable party, such as an employer and/or its Workers' Compensation Insurance carrier.

The purpose of the Medicare Set-Aside Arrangement (MSA) is to provide funds to an injured worker to pay for future medical expenses that would otherwise be covered by Medicare, otherwise known as “qualified medical expenses”. If the injured worker incurs qualified medical expenses that exhaust the anticipated annual amount, Medicare will pay for any excess expenses. By establishing a Medicare Set-Aside Account, parties to a settlement are protecting Medicare’s interest and complying with the Medicare Secondary Payer Act.

Non-Liquid Resources: Property that is not cash and that cannot be converted to cash within 20 days.

Examples of Non-Liquid Resources:

1. A home;
2. Additional pieces of property;
3. Trailer houses;
4. Burial spaces;
5. Motor vehicles;
6. Life estates;
7. Farm and business equipment;
8. Livestock;
9. Poultry and crops; and
10. Household goods and other personal effects.

477-000-037 – Medically Needy Standard

Medically Needy Income Level
The following figures are used for Medicaid or SIMP budgeting.

Number of Individuals	One Month
	$
1	392.00
2	392.00
Individual in long term care facility	50.00
Individual in Assisted Living with Waiver Services	733.00

477-000-038 – Life Estate and Remainder Interest Table

The life estate chart may be used whenever it is necessary to determine the value of a client's life estate interest in real property. For example, if a client gives away a life estate in real property, this may be considered a deprivation of a resource if the client is in a medical facility. To determine the value of the resource the client disposed of, use this chart.

Find the client's age in the Age column and then go to the column called Life Estate. Take the percentage listed here and multiply it by the TOTAL value of the real property. This will give you the value of the client's life estate interest.

For example, if a client has a life estate in real property and the life estate is deeded to the client's relatives within 60 months of the client entering a nursing home, this may be considered a deprivation of a resource. If the total value of the property is $40,000 and the client is 72 years old, you would take $40,000 x .57261 and the client's life estate interest was worth $22,904.40. The remainder amount to the relatives is $17,095.60 ($40,000 X .42739 in remainder column). The life estate tables may also be used if the owners wish to sell the property and need to know how much of the net proceeds the client should receive or if the owners wish to purchase the life estate interest from the client.

Life Estate Remainder Chart
(rev. September 15, 2009)

AGE	LIFEESTATE	REMAINDER
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300

AGE	LIFEESTATE	REMAINDER
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187

Life Estate Remainder Chart
(rev. September 15, 2009)

AGE	LIFEESTATE	REMAINDER
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126

AGE	LIFEESTATE	REMAINDER
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304

Life Estate Remainder Chart (rev. September 15, 2009)		
AGE	**LIFEESTATE**	**REMAINDER**
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641

AGE	LIFEESTATE	REMAINDER
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450

Life Estate Remainder Chart (rev. September 15, 2009)		
AGE	**LIFEESTATE**	**REMAINDER**
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

477-000-039 – Life Expectancy Tables

From Social Security Online's Actuarial Publications "Period of Life Table."
A period life table is based on the mortality experience of a population during a relatively short period of time. Here we present the 2010 period of life table for the Social Security area population. For this table the period life expectancy at a given age represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for 2010 over the course of their remaining life.

Period Life Table, 2010 Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
0	0.006680	100,000	76.10	0.005562	100,000	80.94
1	0.000436	99,332	75.62	0.000396	99,444	80.39
2	0.000304	99,289	74.65	0.000214	99,404	79.43
3	0.000232	99,259	73.67	0.000162	99,383	78.44
4	0.000172	99,235	72.69	0.000132	99,367	77.46
5	0.000155	99,218	71.70	0.000117	99,354	76.47
6	0.000143	99,203	70.71	0.000106	99,342	75.47
7	0.000131	99,189	69.72	0.000099	99,332	74.48
8	0.000115	99,176	68.73	0.000093	99,322	73.49
9	0.000096	99,164	67.74	0.000090	99,313	72.50
10	0.000082	99,155	66.74	0.000090	99,304	71.50
11	0.000086	99,147	65.75	0.000096	99,295	70.51
12	0.000125	99,138	64.76	0.000111	99,285	69.52

Period Life Table, 2010 Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
13	0.000205	99,126	63.76	0.000137	99,274	68.52
14	0.000319	99,106	62.78	0.000170	99,261	67.53
15	0.000441	99,074	61.80	0.000207	99,244	66.54
16	0.000562	99,030	60.82	0.000245	99,223	65.56
17	0.000690	98,975	59.86	0.000282	99,199	64.57
18	0.000820	98,906	58.90	0.000318	99,171	63.59
19	0.000949	98,825	57.95	0.000352	99,139	62.61
20	0.001085	98,731	57.00	0.000388	99,105	61.63
21	0.001213	98,624	56.06	0.000423	99,066	60.66
22	0.001304	98,505	55.13	0.000454	99,024	59.68
23	0.001345	98,376	54.20	0.000476	98,979	58.71
24	0.001350	98,244	53.27	0.000494	98,932	57.74
25	0.001342	98,111	52.34	0.000511	98,883	56.77
26	0.001340	97,980	51.41	0.000531	98,833	55.79
27	0.001342	97,848	50.48	0.000553	98,780	54.82
28	0.001356	97,717	49.55	0.000579	98,726	53.85
29	0.001380	97,584	48.62	0.000608	98,668	52.88
30	0.001408	97,450	47.68	0.000641	98,608	51.92

Period Life Table, 2010 Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
31	0.001435	97,313	46.75	0.000677	98,545	50.95
32	0.001466	97,173	45.82	0.000719	98,479	49.98
33	0.001499	97,031	44.88	0.000765	98,408	49.02
34	0.001539	96,885	43.95	0.000818	98,332	48.06
35	0.001592	96,736	43.02	0.000879	98,252	47.10
36	0.001660	96,582	42.08	0.000948	98,166	46.14
37	0.001741	96,422	41.15	0.001022	98,073	45.18
38	0.001837	96,254	40.22	0.001100	97,972	44.23
39	0.001953	95,077	39.30	0.001185	97,865	43.27
40	0.002084	95,889	38.37	0.001279	97,749	42.32
41	0.002241	95,689	37.45	0.001387	97,624	41.38
42	0.002439	95,475	36.53	0.001518	97,488	40.43
43	0.002686	95,242	35.62	0.001676	97,340	39.50
44	0.002975	94,986	34.72	0.001858	97,177	38.56
45	0.003297	94,704	33.82	0.002055	96,997	37.63
46	0.003639	94,392	32.93	0.002262	96,797	36.71
47	0.003997	94,048	32.05	0.002480	96,578	35.79
48	0.004366	93,672	31.17	0.002709	96,339	34.88

Period Life Table, 2010 Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
49	0.004750	93,263	30.31	0.002947	96,078	33.97
50	0.005156	92,820	29.45	0.003209	95,795	33.07
51	0.005596	92,342	28.60	0.003484	95,487	32.18
52	0.006078	91,825	27.76	0.003751	95,155	31.29
53	0.006605	91,267	26.93	0.004000	94,798	30.40
54	0.007174	90,664	26.10	0.004246	94,418	29.52
55	0.007805	90,013	25.29	0.004520	94,017	28.65
56	0.008464	88,311	24.48	0.004836	93,593	27.77
57	0.009095	88,555	23.69	0.005185	93,140	26.91
58	0.009676	87,750	22.90	0.005570	92,657	26.04
59	0.010245	86,901	22.12	0.006001	92,141	25.19
60	0.010865	86,010	21.34	0.006489	91,588	24.34
61	0.011592	85,076	20.57	0.007046	90,352	22.65
62	0.012444	84,090	19.81	0.007686	90,099	22.63
63	0.013451	83,043	19.05	0.008419	89,658	21.83
64	0.014608	81,926	18.30	0.009249	88,903	21.01
65	0.015927	80,729	17.57	0.010201	88,081	20.20
66	0.017370	79,444	16.84	0.011255	87,182	19.40

Period Life Table, 2010 Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
67	0.018895	78,064	16.13	0.012372	86,201	18.62
68	0.020484	76,589	15.43	0.013538	85,135	17.84
69	0.022191	75,020	14.75	0.014793	83,982	17.08
70	0.024139	73,355	14.07	0.016233	82,740	16.33
71	0.026364	71,584	13.40	0.017882	81,397	15.59
72	0.028808	69,697	12.75	0.019693	79,941	14.87
73	0.031480	67,689	12.12	0.021671	78,367	14.16
74	0.034442	65,558	11.49	0.023866	76,669	13.46
75	0.037855	63,300	10.89	0.026437	74,839	12.77
76	0.041725	60,904	10.30	0.029368	72,860	12.11
77	0.045932	58,363	9.72	0.032519	70,721	11.46
78	0.050469	55,682	9.17	0.035870	68,421	10.83
79	0.055465	52,872	8.63	0.039555	65,967	10.21
80	0.061179	49,939	8.10	0.043828	63,357	9.61
81	0.067698	46,884	7.60	0.048808	60,580	9.03
82	0.074923	43,710	7.11	0.054434	57,624	8.47
83	0.082891	40,435	6.65	0.060762	54,487	7.93
84	0.091725	37,084	6.21	0.067889	51,176	7.41

Period Life Table, 2010 Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
85	0.101575	33,682	5.78	0.075926	47,702	6.91
86	0.112568	30,261	5.38	0.084968	44,080	6.44
87	0.124795	26,854	5.00	0.095093	40,335	5.99
88	0.138305	23,503	4.64	0.106352	36,499	5.56
89	0.153107	20,253	4.30	0.118777	32,617	5.17
90	0.169195	17,152	3.99	0.132384	28,743	4.80
91	0.186543	14,250	3.70	0.147181	24,938	4.45
92	0.205115	11,592	3.44	0.163161	21,268	4.13
93	0.224867	9,214	3.20	0.180314	17,798	3.84
94	0.245744	7,142	2.98	0.198615	14,588	3.58
95	0.266454	5,387	2.79	0.217125	11,691	3.34
96	0.286625	3,952	2.62	0.235558	9,153	3.13
97	0.305869	2,819	2.47	0.253602	6,997	2.94
98	0.323783	1,957	2.34	0.270923	5,222	2.76
99	0.339972	1,323	2.22	0.287178	3,807	2.60
100	0.356971	873	2.10	0.304409	2,714	2.45
101	0.374819	562	1.99	0.322673	1,888	2.31
102	0.393560	351	1.88	0.342033	1,279	2.17

Period Life Table, 2010 Exact age	Male			Female		
	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
103	0.413238	213	1.78	0.362555	841	2.03
104	0.433900	125	1.68	0.384309	536	1.91
105	0.455595	71	1.59	0.407367	330	1.79
106	0.478375	39	1.50	0.431809	196	1.67
107	0.502293	20	1.41	0.457718	111	1.56
108	0.527408	10	1.32	0.485181	60	1.45
109	0.553778	5	1.24	0.514292	31	1.35
110	0.581467	2	1.17	0.545149	15	1.26
111	0.610541	1	1.09	0.577858	7	1.17
112	0.641068	0	1.02	0.612530	3	1.08
113	0.673121	0	0.95	0.649282	1	1.00
114	0.706777	0	0.89	0.688238	0	0.92
115	0.742116	0	0.83	0.729533	0	0.84
116	0.779222	0	0.77	0.773305	0	0.77
117	0.818183	0	0.71	0.818183	0	0.71
118	0.859092	0	0.66	0.859092	0	0.66
119	0.902047	0	0.60	0.902047	0	0.60

477-000-040 – State Review Team Information

Requirement of Medical Information

Existence and permanence of an impairment must be determined from the findings reported by the physician following a diagnostic examination of the applicant. The report may also be made from information in existing medical records, such as those of the physician or of a clinic or hospital in which the applicant has been a patient if the treatment received was directly related to the disability impairment, and the applicant has been treated by the physician or had been a patient in the clinic or hospital within the year preceding the application or reapplication. The SRT will accept supporting medical documentation 12 months prior to the application date. However, there must be medical information for the time period being considered by the SRT and current information from an examination which occurred within three months of the application.
If the applicant has requested consideration of an earlier onset of disability than the month of review by the SRT, medical information pertinent to that time period must be provided.

SRT Decision

The SRT considers the medical and social information submitted and determines if the applicant is disabled or blind. The SRT shall report their findings via Form DM-5R.

Review of Disability

Information for the review of disability must be submitted to the SRT before the date specified on Form DM-5R. New medical and social information shall be provided and any additional medical information requested on the original Form DM-5R in order for the SRT to complete redetermination of disability.

If the client is disabled according to SSI but is no longer eligible for SSI because of excess income and/or resources, the client is considered disabled according to SSI standards for a period of 12 months following the month of the last SSI payment as long as all other eligibility factors are met (e.g. income, resources). To continue AABD/MA at the end of the 12-month period, a review of disability by SRT is needed.

If the SRT has determined disability for the client and SSI later determines that the client is not disabled due to lack of severity or the ability to engage in substantial gainful activity, and if the client has filed an appeal with SSI, the client must be considered disabled through the review period established by the SRT on the most current Form DM-5R. If no appeal has been filed and the worker is closing the case before the end of the current SRT period, the closing notice must tell the client to contact his/her DHHS immediately if an appeal is filed. This is so the Medicaid case can be reopened for the remainder of the SRT period. At the end of the current review period, the worker closes the case without referring it to the SRT.

Review
When change occurs which may raise questions affecting the disability status and continued medical eligibility, SRT shall be notified.

Payment for Examination and Transportation: The cost of medical examinations to determine initial or continuing eligibility may not exceed the established fee. The cost of a medical examination to determine eligibility is an allowable Title XIX expenditure if the individual is eligible for medical benefits on the date of the examination. If the initial application is rejected, the cost of the examination must be paid from administrative funds. The cost of transportation necessary to secure the examination, and subsistence expense when it is necessary for the individual to secure the required services away from home are paid from administrative funds if the application is rejected. If the application is approved, the cost of transportation and subsistence expense is allowed in the budget as a special need.

477-000-041 – RSDI Verification

Generally RSDI (Social Security) is verified by the Bendex for current recipients of AABD/MA. Changes in benefits for current recipients are reported on N-FOCUS via the BDE interface and are used to determine the following month's budget, taking into consideration the Request. This procedure does not apply to discrepancies with the buy-in. When a client is current pay SSI verification of other income or resources are not required.

The State Data Exchange (SDX) must be used to verify receipt of SSI benefits and determine the correct federal benefit rate. Changes in SSI benefits for current recipients are reported on N-FOCUS via the SDX interface. The ten-day notice requirement must be used. When there is a discrepancy in the verified amount of the check and the Bendex for the month of the check, a SVES SDX must be initiated to verify the amount of periodic extra earned income or periodic unearned income to be used in a client's AABD/MA budget if s/he is in non-pay status for SSI for one month due to the receipt of this periodic income.

This may be Net Countable Unearned Income, Deemed Income, or Net Countable Earned Income of the client. The amount of income from any of these fields may be used from the SDX and counted in the client's budget, if it has been updated by SSI. No income disregards are allowed as they have already been allowed by SSI. If the client receives periodic unearned income, e.g., life estate income received annually or semi-annually, or deemed income from a spouse/parent, it is counted for medical budgeting. Approval of an application must not be delayed if all eligibility factors are met but is unable to obtain verification of the amount of any RSDI and/or SSI benefits due to SSA's delay in determining the amount(s).

If a disabled client is not yet receiving RSDI, medical budgets must be computed without the RSDI income. At the time of approval, the client must be notified on a Notice of Action that s/he must report receipt of any RSDI and/or SSI benefits. The RSDI must be included in the budget in the first month possible considering the ten-day notice requirement.

477-000-042 – SIMP Procedures for AD Waiver at Home

Both members of the couple are either aged or disabled (both categorically eligible):

A. One spouse has already met the 30 day facility care rule (Assessment of Resources) and is now applying for AD Waiver or PACE at home for one.

1. Current resources must be no more than the IM-73 reserved amount + $4,000.
2. Complete the IM-74 and begin spousal (SIMP) budgeting with the month that AD Waiver or PACE services actually begin.
3. Do not open the Medicaid SIMP case and use SIMP until you know what month Waiver or PACE is activated. Waiver or PACE and Medicaid need to coordinate this.

B. Neither spouse has met the 30 day facility care rule and is now applying for AD Waiver or PACE at home for one.

1. Resources must be no more than $6,000 for the eligible couple.
2. Make the AD Waiver referral. Provide waiver with a "test budget" with the couple budgeted separately so the Waiver knows what the SOC, if any, will be if they approve waiver for one.
3. Open the Medicaid case with the appropriate FPL or SOC **together.**
4. When/if AD Waiver or PACE notifies they are beginning services, then do a recalculated budget and budget the couple separately for the month waiver begins for one.
5. If the non-waiver or non-PACE spouse does not need or want Medicaid, then close that spouse for the come-up month and use SIMP budgeting because the 30-day rule has now been met. (If less than 10 days, have the spouse waive 10-day notice.)

Only one of the members of the couple is aged or disabled (categorically eligible):

A. One spouse has met the 30 day facility care rule and is now applying for AD Waiver or PACE or at home for one: Follow all the steps 1 through 3 in A above.

B. Neither spouse has met the 30-day facility care rule, and one is now applying for AD Waiver or PACE at home.

1. Resources must be no more than $6,000 for the couple residing together in the home.
2. Make the AD Waiver referral and provide waiver with a test "together" budget. This means with both spouses' income, and may be a SOC.
3. Open the Medicaid case for the eligible spouse (participant) and include the ineligible spouse's income. If there is a SOC, set the case to spend down status.
4. At the end of the 30 day period of receipt of AD at home Waiver or PACE:
    a. Complete the Assessment and the Designation of Resources (IM-73 and IM-74);
    b. Recalculate the budgets using SIMP budgeting, beginning with the month in which at home Waiver or PACE services began, and forward.

TIPS:

1. You can never use SIMP budgeting for any month that the non-waiver spouse was a participant/eligible on the system. This includes in spend down status with a SOC form.
2. A disabled or aged spouse cannot choose to be ineligible until one spouse has met the 30-day requirement for Spousal (either facility or at home waiver or PACE).
3. Setting a Waiver or PACE client to active status means you have obligated any SOC to the waiver services billing.

477-000-043 – Procedures for Assisted Living and Assisted Living Waiver Services

Points to remember about AL and ALW Services:

1. There is no Medicare certification for Assisted Living Waiver Services, so the SON will change the first full month of authorized Waiver services.
2. Always use the highest appropriate SON for the month of entry into Assisted Living.
3. There is no remedial care allowance for Assisted Living Waiver, only Assisted Living.
4. The client must be Waiver eligible (need nursing home level of care) and have an Aged and Disabled Waiver case established in order to be considered Assisted Living Waiver.
5. The SON for Assisted Living, as well as Assisted Living Waiver, includes the personal needs allowance. To arrive at the actual room and board payment, the client would pay the facility, you need to subtract the Personal Needs Allowance from the total SON.
6. Deprivation of resource rules do apply to Assisted Living Waiver, but not to Assisted Living except for grant.
7. Both Assisted Living and Assisted Living Waiver budgets get the $20 disregard.
8. The begin date for Waiver is the date payment for waiver services begins. This date is not necessarily the same as the Waiver assessment date.
9. If both spouses are in Assisted Living and only one needs Waiver services, the other spouse may be a community spouse.

See 477-000-042 for spousal procedures when there is Waiver at home.

For N-FOCUS budgeting steps for Assisted Living and Assisted Living with Waiver, see the "How To" Help in N-FOCUS.

477-000-044 – AABD Standard of Need

The AABD Standard of Need is used to determine when a referral is needed for payment and for remedial care calculation for a Medicaid budget.

AABD Standard of Need	
Number in Unit	**Standard**
1	$449
2	$730
3	$910
4	$1,095
5	$1,280
6	$1,465
7	$1,650
8	$1,835
9	$2,020
10	$2,205
Each additional person	$185

Standard of Need	
Nursing Home, Public Institution for the Treatment of Mental Diseases and/or Mental Retardation	$50
Personal Needs Allowance of $64 is included in the living arrangements listed:	
Maximum Board and Room *Drug Treatment Centers are budgeted as Board and Room unless Medicaid is paying. If Medicaid is paying, use $60.	$725
Maximum for Licensed or Non-Licensed Boarding Home (providing board and room)	$725
Certified Adult Family Home	$853
Licensed Assisted Living Facility	$1163
Assisted Living Waiver	$733
Licensed Group Home for Children and/or Child Caring Agency	$789
Licensed Center for the Developmentally Disabled	$725
Licensed Maternal Health Center	$1163

Maximum Shelter Allowance	
Single Shelter Amount	$281
Multiple Shelter Amount	$349

SSI Referral Amounts	
Single Individual	$753
Couple	$1120

477-000-045 – Share of Cost

If net income for the month exceeds the medically needy income level, a client may be determined eligible for medical assistance with a share of cost (SOC) if:

1. A medical need exists or can reasonably be anticipated which meets or exceeds the SOC amount;
2. The client has paid or obligated the SOC for medical care or services for anyone in the unit. If the income of a parent in the home but not in the unit has been considered on the budget, his/her medical expenses (including insurance premiums) may be applied to the child's SOC;
3. The medical care or services have occurred during SOC period; and
4. Obligations or expenditures are substantiated on Form DSS-160.

Note: Medical expenses paid by another state, county, or city program may be used toward the client's obligation if no federal funds are used to pay the medical expense. This would include programs such as county general assistance, the Renal Disease Program or the Medically Handicapped Children's Program. Questions on other programs may be submitted to the Central Office for review.
If an MILTC-53 was submitted an MILTC-64 is needed to determine a SOC budget.

SOC Allowable Obligations:

Medical Service or Supply:
Any medical service or supply is an allowable obligation of an SOC amount, whether or not the service or supply is allowed by Medicaid. This includes the cost of:

1. Transportation to obtain medical care. Mileage is allowed if the client travels by car; if the client uses another form of transportation, the actual cost is allowed; and
2. Meals and lodging when the expense is necessary to obtain approved health services and only if the client is away from home for 12 hours or more per day. The allowance for cost of meals is $12 per day. Additionally, the cost of lodging will be allowed if reasonable and if the client provided receipts. The allowance for meals and lodging may be allowed for an attendant if one is needed to accompany the client.
3. Actual fees for case management services provided by an Area Agency on Aging or a Medicaid provider who is approved to provide case management services. If the client is receiving case management services from some other source, the worker shall outline the circumstances and submit it as a policy question to the Central Office.

The amount the client is responsible for paying toward medical and remedial services while in an alternate living arrangement is an allowable SOC obligation. To arrive at the amount that the client is paying for medical and remedial services, the worker shall subtract the medically needy income level from the applicable consolidated standard of need. If the client is in a long term care facility, his/her SOC should first be applied to the cost of care.

The worker shall inform the client that any expense incurred which is not covered by Medicaid will have to be paid totally by him/her.

Ineligibility for Medicare, Part B Buy-In: When a client has an SOC for AABD, s/he is no longer eligible to receive the state buy-in of Medicare, Part B premium if their income is 120% FPL or above. The Medicare premium will be deducted from the SOC even though a delay of two to three months is usually encountered before the client's benefit check reflects the actual Medicare deduction (net). The Medicare premium may be recouped for these months for which the client was responsible from one month's RSDI benefit.

Medicare Part A Premium: If a client is enrolled in premium Part A Medicare and is paying his/her own premium, this is an allowable SOC.

Pre-placement Visits:
When it has been determined that an individual residing in a nursing home no longer requires nursing home care, the local office has 60 days to arrange for alternate care. In some instances, it may be necessary to arrange for a pre-placement visit to determine the appropriateness of placement in an alternate care facility.
Based on the number of days for the pre-placement visit, the prorated amount for the alternate care facility is deducted from the SOC for the month of the pre-placement visit.
The client shall provide a listing of providers, dates, and amounts for transportation, meals, and lodging.

SOC and Medical Insurance:
When a client with an SOC has medical insurance (including Medicare, worker's compensation, etc.), the following procedures apply:

1. The client or medical provider submits a claim for payment to the insurance company before consideration of the SOC amount;
2. The client or medical provider provides to the worker verification of allowance or disallowance of the claim by the insurance company (i.e., Medicare EOB's, or other insurance benefit explanation forms);
3. The amount that the insurance company allowed must not be counted toward the individual's SOC; and
4. The amount of the claim for which the client is responsible is counted toward the SOC amount.

This procedure applies to all persons whose medical expenses are being used to meet the client's SOC.

Monitoring Client's SOC Obligation

In order for the client to meet his/her SOC obligation, the client will take his/her monthly SOC form (DSS-160) to medical providers as s/he receives medical services for the month noted on the form. The medical provider that provides the last service necessary to meet the SOC will send the completed DSS-160 to Central Office.

When the client has met his/her monthly SOC obligation, the Central Office makes appropriate changes to N-FOCUS.

Medical coverage is effective the first of the month for medical bills not used to meet the SOC obligation for covered services.

If the client never meets the obligation, no medical bills are paid for that month. The client may meet that obligation at a later time.

When the case is reviewed, the worker re-evaluates the case to determine if a medical need will continue. The worker then -

1. Closes the case and send a Notice of Action if there is no medical need. The Notice of Action notifies the client that s/he may reapply if there is a medical need at a later date. Claims incurred after the close date are not paid; or
2. The case remains SOC if there is a continuing medical need.

Spenddown Procedures for Institutionalized Individuals

Reduction of Standard of Need

If an ongoing recipient who is on Medicaid enters a long term care facility, the standard of need must be reduced to $50.00 the first full month of institutionalization in which there is no Medicare involvement. This requires adequate notice only.

If an ongoing recipient who is in an SOC period enters a long-term care facility, the standard of need must be reduced to $50.00 the first full month of institutionalization in which there is no Medicare involvement.

Exception: The standard of need for a SSI client in their own household is used up to three months when SSI notifies the agency that the client will receive their full SSI payment for three months as the individual is likely to return to his/her previous living arrangement. Use non-SSI budgeting procedures for individuals in long-term care when SSI does not make a change in living arrangement at the end of three full continuous months and income exceeds the FBR for a single individual in an institution.

Change in Facilities

If the client moves from one facility into another during the same month, the SOC is applied to the care received in the first facility. If the SOC is greater than the cost of care, the SOC is split and the remainder applied to the second facility.

If the client leaves the facility and enters another type of facility in the same month where the service is completely covered by insurance, e.g., Medicare extended, any income that is not obligated to the first facility becomes a resource. If, in the following month(s), the insurance coverage continues and the client is unable to obligate the SOC to the care facility the income is treated as regular SOC and set up in an SOC period.

Computation When Income Exceeds Per Diem Rates

When a client who is in a long term care facility or institution has income that exceeds Medicaid's per diem rates, the client must pay his/her full cost of care a Medicaid rates on a monthly basis. In addition, s/he must obligate income that exceeds the full cost of care at Medicaid rates for other medical services.

The following occurs:

1. The worker computes a medical budget for the SOC amount;
2. N-FOCUS calculates any additional SOC amount to be paid. This additional amount may be used for private pay days or other medical. N-FOCUS only calculates this additional SOC amount if the Medicaid per diem expense has been entered by the Long Term Care interface or the worker.
3. If the worker wants N-FOCUS to calculate the private pay days, s/he must enter the private pay per diem as an expense.
4. Technical help for N-FOCUS may be obtained from Production Support; and
5. The worker completes the prior authorization document, when appropriate.

Computation for Changes in Income or Reimbursement Rate

When the client's income or the Medicaid reimbursement rate for the facility increases or decreases during an SOC period, the worker shall -

1. Compare the resulting income figure to the cost of care;

2. Notify the client if there is a change in the amount of the cost of care at Medicaid rates that the client must obligate and determine the amount of SOC that exceeds the cost of care by subtracting the total income from the total cost of care.

   a. If the SOC increases or decreases, notify the client of the new amount; and
   b. Document in the case record.

Note: If the cost of care at Medicaid rates increases after the client's obligation has been met, the client is not responsible for the increase in the cost of care. Because the client's total income has already been obligated, the worker continues to enter the original care rate on N-FOCUS.

Monitoring Client's SOC Obligation

In addition to being responsible for his/her full cost of care at Medicaid rates, the client must obligate the SOC.

The client may use the following to meet his/her SOC obligation:

1. The difference between the private per diem rate and the Medicaid rate;
2. Other medical services or supplies (see above SOC allowable obligations); or
3. A combination of items 1 and 2.

The system generates Form DSS-160. When the client has met his/her total obligation, the Central Office makes the necessary system changes. The worker completes the prior authorization document, when appropriate, and continues to monitor the client's obligation. The worker shall document in the case record.

477-000-046 – Procedures for Medicaid Insurance for Workers with Disabilities

Test A Income Steps

1. Disregard all the disabled individual's earned income.
2. Disregard all the disabled individual's unearned income that is based on a trial work period:
    a) Social Security Disability payment is disregarded if he/she is in a trial work period. The worker must contact Social Security to verify the trial work period.
    b) VA Disability payment, Worker's Compensation payment, Civil Service disability, and private disability insurance must be verified with the source to determine if the receipt of the payment is based on that source's trial work period.
3. Count all other unearned income for the disabled individual and spouse.
4. Count the spouse's net earned income ($65 + 1/2 disregarded).
5. Total the countable income for the individual or couple; if
    a) Greater than the single or couple FBR ($733 or $1,100) = Fail Eligibility
    b) Less than or equal to the single or couple FBR ($733 or $1,100) = Pass and go to Test B.

Test B Income Steps

1. Calculate the countable earned income. Give the $65 + 1/2 disregard to the individual or couple. [The disabled individual's earned income IS counted, unlike Test A]
2. Calculate all gross unearned income for the individual or couple. Allow appropriate medical budget disregards.
   [The disabled individual's unearned income that was disregarded in Test A is now counted]
3. Total all countable income for the individual or couple.
    a) If countable income is EQUAL to or GREATER than 250% of Federal Poverty Level for the household = FAIL eligibility for Medicaid Insurance for Workers with Disabilities. Reject the case with a manual IM-8 unless the individual chooses a share of cost.
    b) If countable income is LESS than 200% of Federal Poverty Level for the household [101% through 199%] = PASS eligibility for Medicaid Insurance for Workers with Disabilities and is fully Medicaid eligible with NO MONTHLY PREMIUM PAYMENT. [200% FPL 1 = $1,962 2 = $2,656]
       The disabled individual would also be eligible for Medicare Part B buy-in.
    c) If countable income is 200% to 250% of Federal Poverty Level [200% through 249%] = PASS eligibility for Medicaid Insurance for Workers with Disabilities WITH A MONTHLY PREMIUM PAYMENT [See chart]

The disabled individual is NOT eligible for Medicare Part B buy-in.

Trial Work Period

Social Security Disability Insurance (SSDI) Trial Work Periods are as follows:

Trial Work Period: This is a period of nine months, which are not necessarily consecutive, during which an SSDI client earns more than $770 a month. The SSDI client's benefits are not affected by the earnings during this nine-month period.

Cessation Month: This is the month, in which SSA determines that the SSDI client's earnings are "substantial", i.e., over the $1,090 Substantial Gainful Activity (SGA) level and benefits are to cease. This is the tenth month following the nine-month Trial Work Period.

Grace Months: These are the two months (months 11 and 12) following the cessation month for which SSDI benefits may be paid even though the client has earnings in excess of the SGA level.

Extended Period of Eligibility: If an SSDI client is medically disabled and continues to work, his/her benefits can be reinstated anytime during the 36 months following the nine-month Trial Work Period. Clients will receive their full SSDI benefit any month that their earnings fall below $1,090. SSDI benefits will continue any of these 36 months that the client does not earn $1,090. These 36 months are consecutive.

All of the above are considered Trial Work Periods for Test A, i.e., disregarding earned income and unearned income contingent upon a Trial Work Period. We consider SSDI's Trial Work Period (nine months), Cessation Month (one month), Grace Months (two months) and Extended Period of Eligibility (36 months) all Trial Work Period months and disregard SSDI unearned income in Test A. In determining which month of the Trial Work Period the client is in or if s/he is in a Trial Work Period, the worker should contact the Social Security Administration.

Disability Determination

Individuals currently receiving a Social Security Disability payment (SSDI) will not need an additional disability determination. All other individuals considered for this program must have a disability determination from the State Review Team (SRT). The following procedure is for SRT determination.

State Review Team Referral Process

WHO:

1. Individuals who have been terminated from SSI 1619(b) or State 1619(b) because of time limit or earnings exceed limit. Do NOT close case while the SRT referral is pending.
2. Individuals that receive Veterans Disability, Railroad Disability, Worker's Compensation or other disability payments.
3. Individuals who allege disability but receive no disability benefits.
4. Individuals who do not get an SSDI check and have used up the 36-month Extended Period of Eligibility.

WHAT:

1. A completed DM-5 and related medical documentation
2. A completed DM-12D
    a) At the top of page one check the MIWD box.
    b) On page three, item 11A, specify the individual's gross monthly earned income AND the weekly number of hours worked.

SRT will make a decision on the disability and send a DM-5R to the worker to take appropriate action.

PREMIUM PAYMENT CHART

ONE

$ 981 - 1,961 = $0
1,962 - 2,059 = 40
2,060 - 2,157 = 84
2,158 - 2,255 = 132
2,256 - 2,353 = 183
2,354 - 2,452 = 238

TWO

$1,328 - 2,654 = $0
2,655 - 2,752 = 54
2,753 - 2,883 = 114
2,884 – 3,014 = 179
3,015 - 3,145 = 250
3,146 - 3,277 = 325

PREMIUM PAYMENT PROCESS:

Medicaid Insurance for Workers with Disabilities will work much like TMA Premium Payments. The client must pay the full premium to the worker no later than the 21st of the month following the month for which the payment is designated.

477-000-047 – Examples: Transitional Medical Assistance

If a family qualifies for TMA (Transitional Medical Assistance), they are entitled to the first six months of eligibility without regard to income. However, beginning with Month 7 the family is subject to an income test. The family loses TMA eligibility if the countable earned income is greater than 185% FPL for the appropriate household size.

The countable income is determined by averaging the gross monthly earned income and subtracting the cost of child care (including that amount paid by Child Care Assistance). No other disregards are allowed.

Note: Unearned income is not considered in TMA budgeting. The Quarterly Report Forms (QRF) ask for this but it is not needed.

In order to determine the household's income, earnings and child care costs from the first three months of TMA are reported via a QRF (Quarterly Report Form). Income from the first QRF (for Months 1, 2 and 3) are used to determine whether the family is eligible for TMA beyond Month 6. Assuming that the QRF and income verification are provided, there are three possible outcomes:

1. The countable income from Months 1 through 3 is greater than 185% FPL and is reflective of the current employment situation, TMA eligibility does not exist beyond Month 6 and the TMA case should be closed allowing for timely and adequate notice. Eligibility for Medicaid should be explored.

2. The countable income is less than 100% FPL and all TMA unit members remain eligible for TMA without any premium.

3. The countable income falls between 100% and 185% FPL. The premium, may apply to all TMA unit members or only to the adult(s). Since TMA is considered non-MAGI, we will run the budgets with the children as non-filers to place them in a MAGI child program (if applicable) and the adults would remain in the TMA premium. If the children are not eligible for the MAGI child program then the whole unit would be included in the TMA premium. TMA premium amounts are found below. The household must be notified of their premium.

WHO PAYS THE PREMIUM? The TMA premium may be required only for the adult(s) in the family; it may also be required for the child(ren). This will depend on the income, family size, composition of the family, and ages of the children. Another factor that must be considered is whether the child(ren) are covered by creditable health insurance. If the children pass eligibility for Medicaid or CHIP, they would not have a premium.

If the parent(s) choose to have a share of cost (SOC) in lieu of the TMA premium, all eligibility factors for medically needy must be met. For example, deprivation, a medical need, resources, a valid application.

Before approving a TMA premium, review each individual for continuous eligibility.

Note: Please do not close the TMA case if the client has not paid their premium. The client will not receive Medicaid services for that month if the premium is not paid.

Alaskan Natives and American Indians who provide verification of their tribal affiliation are not required to pay a premium. This determination is handled by Central Office.

Example 1: Household consists of Mom (age 23) and one child, age 4. The first QRF indicates that the countable monthly income is $1,300. Mom does carry health insurance on both herself and her child. One hundred percent FPL for a two-person household is $1,293, so this family may be subject to a TMA premium. The last eligibility review was completed five months ago.
Factors to Consider:
 This is a single-parent household, so deprivation exists for Mom.
 The child is under age 6 so would be budgeted at 145% FPL. CHIP is not an option due to the health insurance coverage.
 The last eligibility renewal was less than six months ago, but because it was not the initial determination, the child is not assured of any period of continued eligibility so may be subject to a premium along with Mom, if the child fails the applicable Medicaid category.

Result: The Mom in this case must make a decision. The income exceeds the guidelines for a household size of two, so she would be subject to a SOC if we were to close the TMA and run her through "regular" Medicaid budgeting. The income is less than 145% FPL for two, so the child would remain eligible without a SOC. Mom would remain on TMA with a premium while the child would be eligible for Medicaid.

Example 2: Household consists of a married couple with two children, ages 16 and 14. Both parents work and the QRF shows their combined gross earned income to be $2,900 per month. TMA is entering Month 7. The countable income exceeds 100% FPL for a four-person household, yet it is less than 213% FPL. The children are covered by creditable health insurance.
Factors to Consider:
 The parents are subject to the 100 Hour Rule, so if we want to cover them we would need to keep the TMA case open or have an incapacity determination from SRT.
 Regardless of the 100 Hour Rule, the family's countable income exceeds the medically needy income level (MNIL) for four (the parent's income standard) and also exceeds 133% FPL for four (the children's income standard).
 Although the countable income is less than 213% FPL, we cannot close the parents and run the children in CHIP because the children are insured.

Result: In this case, all four family members are subject to the TMA premium. The premium amount is based on the chart listed below.

Example 3: Single parent mother, age 28 with one child, age 9. Household has been on TMA for six months as Mom is employed full-time. The QRF shows that Mom earns $1,400 per month and pays no child care. Mom does not have health insurance coverage on herself or her child.
Factors to consider:
 This is a single-parent household, so deprivation exists without applying the 100 Hour Rule.
 Mom's countable income falls between 100% and 185% FPL, so she would appear to be subject to a TMA premium.
 Mom's income clearly exceeds the MNIL for two, so the result would be a large SOC.
 There is no health insurance coverage and the income is below 213% FPL, so the child would be Medicaid eligible.

Transitional Medical Timeline

The Medicaid client calls to report that she has found a job. The budget is updated and the client fails Parent/Caretaker Relative group. The client has received Medicaid (without a Share of Cost) in three of the previous six months.

Note: While earnings (and cost of child care as appropriate) must be reported on a quarterly basis completion and/or return of the Quarterly Report Form (QRF) is NOT an eligibility requirement. The client may only provide the requested information required on the form.

The following is a "timeline" example illustrating TMA notice and reporting requirements:
August 10: The client is determined ineligible due to earnings. Staff sends notice advising the client that Transitional Medical begins effective 9/2013. N-FOCUS sets the TMA Begin Date as 09/2013.

MONTH 1 - September; 1st month of TMA. No action necessary.

MONTH 2 - October; 2nd month of TMA. No action necessary.

MONTH 3 - November; 3rd month of TMA; the first QRF is mailed to the client at the end of this month. The first Quarterly Report Form is due by the 10th day of month 4 (December).

MONTH 4 - December; 4th month of TMA; the first QRF is due by the 10th. No action is REQUIRED at this point if the QRF is not received timely.

MONTH 5 - January; 5th month of TMA. No action necessary.

MONTH 6 - February; 6th month of TMA; the 2nd QRF is mailed to the client at the end of this month. Use income from months 1, 2, & 3 to calculate the budget for month 7.

1st quarter's report of earnings received		**1st quarter's report NOT received**
Compute budget (income/child care costs)		CLOSE CASE FOR MONTH 7
Compare result to 185% FPL		Case manager must send timely notice
Income < 185% FPL	Income > 185% FPL	
TMA continues. Subject to premium if income exceeds 100% FPL.	Determine eligibility for MED (must send timely notice).	

Note: If the first quarter's earnings are received within 90 days of the closure date, the closure is lifted and TMA continues.

MONTH 7 - March; 7th month of TMA; the 2nd QRF is due by the 10th. Use income from months 4, 5, and 6 to calculate budgets for months 8, 9 & 10.

2nd quarter's report of earnings received	**2nd quarter's report NOT received**
Compute budget (income/child care costs)	CLOSE CASE FOR MONTH 8
Compare result to 185% FPL	Case manager must send timely notice

Income < 185% FPL	Income > 185% FPL
TMA continues. Subject to premium if income exceeds 100% FPL.	Determine eligibility for MED (must send timely notice).

Note: If the second quarter's earnings are received within 90 days of the closure date, the closure is lifted and TMA continues.

MONTH 8 - April; 8th month of TMA. No action necessary.

Note: If the second quarter's earnings are received within 90 days of the closure date, the closure is lifted and TMA continues.

MONTH 9 - May; 9th month of TMA; the 3rd QRF is mailed to the client at the end of this month, and is due by 10th day of month 10.

MONTH 10 - June; 10th month of TMA; the 3rd QRF is due by the 10th. Use income from months 7, 8, & 9 to calculate budgets for months 11 and 12. If the income verification is not received, benefits should be closed for month 11.

MONTH 11 - July; 11th month of TMA. No action necessary.

NOTE: If the third quarter's earnings are received within 90 days of the closure date, the closure is lifted and TMA continues. TMA should not continue past month 12.

Good Cause for Failing to Submit Information Required from the QRF: For later QRF reporting due to a client claiming good cause please send the case to Central Office for review.
477 NAC 24-005.08

MONTH 12 - August; 12th month of TMA. At the end of month 12, the TMA case needs to be closed. Determine if a renewal form was sent to the client and what action is needed. Eligibility for Medicaid (but not TMA) shall be determined for all family members. The family cannot receive TMA again until they can meet the "3 out of 6" test again.

Note: Anytime TMA is terminated due to failure to provide verification of income or if the income is in excess of 185% FPL, the children and any medically needy individual must be reviewed for continuous eligibility and eligibility under other programs if all requirements are met (i.e. a current application/renewal form and income are on file, deprivation, etc.)

Transitional Medical Assistance – Examples

TMA Example 1

Parent/caretaker relative (P/CR) Medicaid case becomes ineligible for Medicaid effective April due to increased earnings of the parent/caretaker relative. The unit has been eligible for Medicaid in 3 of the last 6 months preceding the month of ineligibility. The unit is eligible for the first 6 months of the 12 months of TMA.

TMA Example 2

P/CR Medicaid case becomes ineligible for Medicaid effective April due to increased earnings of the parent/caretaker relative. The unit has NOT been eligible to receive Medicaid in 3 of the last 6 months preceding the month of ineligibility. The unit is NOT eligible for TMA. A Medicaid budget would need to be computed to determine if medical eligibility exists for the unit. Review for continuous eligibility and deprivation.

TMA Example 3

P/CR Medicaid case with no earned income becomes ineligible for Medicaid effective April due to increased collection of spousal support. Assuming the unit had received Medicaid in 3 of the last 6 months preceding the month of ineligibility. The unit is not eligible for TMA since the loss of Medicaid was not due to increased earnings. 477 NAC 24-005.05

TMA Example 4

In May, the Medicaid case is in its 2nd month of the 12 months of TMA. The unit consists of Dad, Mom and a child. The child turns 19 in May and graduates from high school. The unit no longer contains a dependent child.
Ten day notice is given and the TMA case is closed effective 6/1. 477 NAC 24-005.05A

TMA Example 5

The unit consists of Mom and 2 children. They are in their 3rd month of the 12 months of TMA. Mom either marries or the father of the children moves back home. Dad is added to the TMA unit. Mom, Dad and the 2 children would remain eligible for at least the first 6 months of the 12 months of TMA. Dad is added to the unit and his income would have to be counted beginning with month 7 of TMA to determine if the unit is under 185% FPL. 477 NAC 24-005.07D

TMA Example 6

Same situation as Example 5, however, the unit is in the 8th month of the 12 months of TMA when Dad returns to the household. Again, Dad is added to the TMA unit and his income is considered when the three month average income is computed in month 10 to determine if the unit is over 185% FPL for months 11 and 12. Dad is also added to the FPL level. If the unit's income remains under 185% FPL, the family remains eligible for TMA. If the unit's income is over the 185% FPL, the case is closed the end of month 10 and the children's eligibility for Medicaid is determined. Review for continuous eligibility and deprivation.

Note: You would already have received Mom's report of her 3 months earnings in month 10. You would look prospectively at Dad's income for months 11 and 12.

TMA Example 7
The unit consists of Mom and 2 children. They are in their 3rd month of the 12 months of TMA. Mom reports she is pregnant and the father of the unborn has moved in with her. The unborn is added to the unit size as an excluded sibling. Paternity cannot be established for an unborn. The alleged father of the unborn is not added to the unit size and his income would not be counted. Mom and the 2 children would remain in TMA. The alleged father would have no medical coverage unless he is age eligible or disabled and would be a unit size of 1.

TMA Example 8
The unit consists of Mom and 2 children. They are in their 8th month of the 12 months of TMA. One of the children becomes pregnant. Mom and the 2 children remain in TMA and the unborn is added to the unit size as an excluded sibling.

TMA Example 9
The unit consists of Dad, Mom, and 2 children. They are in their 7th month of the 12 months of TMA. Dad is determined disabled by SSA. If Dad would be eligible for AABD Medicaid OR if he is receiving SSI, he must be removed from the TMA unit and budgeted as AABD. If Dad would NOT be eligible for AABD Medicaid or is NOT receiving SSI, he would remain in the TMA unit.

Note: If Dad is eligible for an AABD Medicaid, but removing him from the TMA unit causes the TMA unit to be over the 185% FPL, eligibility for all household members is evaluated.

TMA Example 10
The unit is in the 7th month of the 12 months of TMA. Mom reports an increase in her hourly wage that would put the unit over the 185% FPL. The budget would be computed in month 7 based on the new pay schedule to determine eligibility for months 8, 9, and 10.

TMA Example 11
The unit is in their 1st month of the 12 months of TMA. The case is closed at the end of the first month as the family moved to California. The family is only gone for 1 month and then moves back to Nebraska and reapplies for assistance. Mom is still working and the unit is not eligible for Medicaid because of earnings. The unit has been financially eligible to receive Medicaid or grant in 3 of the last 6 months. They would be eligible for TMA. When the case is reopened they would be in month 1 of the TMA.

TMA Example 12
The unit consists of Mom and 3 children. Mom has been sanctioned due to non-cooperation with Child Support Enforcement (CSE) so she is not included in the Medicaid unit. Mom gets a job that puts the Medicaid over income. The unit has received Medicaid for the last 8 months. The three children are eligible for the first 6 months of TMA. When Mom cooperates with CSE she would be added to the TMA unit. If she subsequently refuses to cooperate with CSE while in the TMA unit, no action is taken as cooperation with CSE is not an issue for TMA. 477 NAC 24-005.05

Note: Cooperation with CSE is an eligibility requirement for Medicaid, except if the client is pregnant or already active in a TMA case at the time of the sanction.

TMA Example 13

The unit consists of Mom, 2 children ages 6 and 3, and an unborn. The unit is eligible for the first 6 months of TMA. They are not eligible for TMA beyond Month 6 because the earned income minus cost of child care exceeds 185% FPL. The TMA case is closed and a MED budget is run. Mom's eligibility is based on the Pregnant Women income standard for four, 194% FPL. If mom fails PW eligibility, she is continuously eligible through her post-partum eligibility. Eligibility of the three children, if uninsured, is based on the applicable income standard for each child.

TMA Example 14

The household has been in TMA since June. In November the employed parent is laid off and requests Medicaid. After the Medicaid eligibility is determined, the parent is recalled to work. There is no Medicaid eligibility for December due to earnings. Because the family was financially eligible to receive a grant or ADC related Medicaid only for November, they cannot begin a new TMA cycle starting with December. However, they may resume the original TMA cycle which began in June. December would be month 7 of the original TMA cycle. 477 NAC 24-005.09

TMA Premium Fee Schedule

NEBRASKA HEALTH AND HUMAN SERVICES
TRANSITIONAL MEDICAL ASSISTANCE (TMA)
PREMIUM FEE SCHEDULE

FAMILY SIZE 1			FAMILY SIZE 2			FAMILY SIZE 3			FAMILY SIZE 4			FAMILY SIZE 5			FAMILY SIZE 6			FAMILY SIZE 7			FAMILY SIZE 8 +		
ADJUSTED MONTHLY EARNED INCOME		Fee	ADJUSTED MONTHLY EARNED INCOME		Fee	ADJUSTED MONTHLY EARNED INCOME		Fee	ADJUSTED MONTHLY EARNED INCOME		Fee	ADJUSTED MONTHLY EARNED INCOME		Fee	ADJUSTED MONTHLY EARNED INCOME		Fee	ADJUSTED MONTHLY EARNED INCOME		Fee	ADJUSTED MONTHLY EARNED INCOME		Fee
981	1029.99	29	1328	1393.99	40	1674	1757.99	50	2021	2121.99	61	2368	2485.99	71	2714	2849.99	81	3061	3213.99	92	3408	3577.99	102
1030	1078.99	31	1394	1459.99	42	1758	1841.99	53	2122	2222.99	64	2486	2603.99	75	2850	2985.99	85	3214	3366.99	96	3578	3747.99	107
1079	1127.99	32	1460	1526.99	44	1842	1924.99	55	2223	2323.99	67	2604	2722.99	78	2986	3120.99	90	3367	3519.99	101	3748	3918.99	112
1128	1176.99	34	1527	1592.99	46	1925	2008.99	58	2324	2424.99	70	2723	2840.99	82	3121	3256.99	94	3520	3672.99	106	3919	4088.99	118
1177	1225.99	35	1593	1658.99	48	2009	2092.99	60	2425	2525.99	73	2841	2958.99	85	3257	3392.99	98	3673	3825.99	110	4089	4258.99	123
1226	1274.99	37	1659	1725.99	50	2093	2175.99	63	2526	2626.99	76	2959	3077.99	89	3393	3527.99	102	3826	3978.99	115	4259	4429.99	128
1275	1323.99	38	1726	1791.99	52	2176	2259.99	65	2627	2727.99	79	3078	3195.99	92	3528	3663.99	106	3979	4131.99	119	4430	4599.99	133
1324	1372.99	40	1792	1858.99	54	2260	2343.99	68	2728	2828.99	82	3196	3314.99	96	3664	3799.99	110	4132	4284.99	124	4600	4770.99	138
1373	1421.99	41	1859	1924.99	56	2344	2427.99	70	2829	2929.99	85	3315	3432.99	99	3800	3935.99	114	4285	4437.99	129	4771	4940.99	143
1422	1470.99	43	1925	1990.99	58	2428	2510.99	73	2930	3030.99	88	3433	3550.99	103	3936	4070.99	118	4438	4590.99	133	4941	5110.99	148
1471	1519.99	44	1991	2057.99	60	2511	2594.99	75	3031	3131.99	91	3551	3669.99	107	4071	4206.99	122	4591	4743.99	138	5111	5281.99	153
1520	1568.99	46	2058	2123.99	62	2595	2678.99	78	3132	3232.99	94	3670	3787.99	110	4207	4342.99	126	4744	4896.99	142	5282	5451.99	158
1569	1617.99	47	2124	2189.99	64	2679	2761.99	80	3233	3333.99	97	3788	3905.99	114	4343	4477.99	130	4897	5049.99	147	5452	5621.99	164
1618	1666.99	49	2190	2256.99	66	2762	2845.99	83	3334	3434.99	100	3906	4024.99	117	4478	4613.99	134	5050	5202.99	152	5622	5792.99	169
1667	1715.99	50	2257	2322.99	68	2846	2929.99	85	3435	3535.99	103	4025	4142.99	121	4614	4749.99	138	5203	5355.99	156	5793	5962.99	174
1716	1765.99	51	2323	2389.99	70	2930	3013.99	88	3536	3637.99	106	4143	4261.99	124	4750	4885.99	142	5356	5509.99	161	5963	6133.99	179
1766	1815.00	53	2390	2456.00	72	3014	3097.00	90	3638	3739.00	109	4262	4380.00	128	4886	5021.00	147	5510	5663.00	165	6134	6304.00	184

477-000-048 – Real Property: Transfer on Death Deed

Ownership of real property must be verified by current recorded deed. A transfer on Death Deed is a revocable recorded deed which transfers real property ownership to another individual upon the death of the owner(s). When the current recorded deed is a transfer on death deed for our applicant/client, or his/her spouse, then the applicant/client is not eligible until that deed is revoked and recorded with the County Clerk or Register of Deeds. Below are the required steps:

1. Current Transfer on Death deed is verified and the copy is contained in the case record.
2. Send Notice of Action requiring revocation of transfer on death deed before Medicaid eligibility can be established. Manual reference 477 NAC 21-001.11B1.
3. Client/spouse goes through the formal process for transfer on death deed revocation and records that revocation deed.
4. Client/spouse sends copy of revocation recorded deed to DHHS.
5. Eligibility determination proceeds.

477-000-049 – Resource Review Verification

A renewal of eligibility is completed every 12 months. At the 12 month renewal, resources will be verified if applicable. Clients and/or beneficiaries are required to report changes within 10 days if it affects eligibility, which includes resources.

477-000-050 – Property Excluded Regardless of Value

Property is excluded regardless of its value if a medical assistance client uses it in a trade or business. The client may be an employee who is required to use the property for his/her work or a self-employed individual who uses the property for his/her business.

EXAMPLE 1:
Mr. Brown owns his own construction business. He owns a garage and lot adjacent to his home in which he stores materials, supplies, and equipment used in his business. He maintains a checking account for the business with a current balance of $1,200.
The garage, lot, checking account, and all materials, supplies, and equipment used for his business are an excluded resource.

EXAMPLE 2:
Mr. Black owns his own hog confinement business. This includes several confinement buildings and the 10 acres they are situated on, 40 acres of farm land used to raise grain for feed, two tractors, a combine, many equipment and machinery items, other supplies for the business, and 50 hogs. He is actively engaged in the day-to-day operation as a primary means of earning a livelihood by performing the labor and making the decisions for the operation.

All land, buildings, livestock, machinery, and other equipment or supplies used for his business are an excluded resource.

Note: If Mr Black owned the operation but contracted out the labor, it would not be excluded because he is not performing a primary work effort.

EXAMPLE 3:
Mr. Green is employed by a local construction company as a carpenter. He is required by his employer to provide all his own tools and necessary equipment for carpentry.
All tools and equipment required by the employer for work are an excluded resource.

EXAMPLE 4:
Mr. Blue is employed by a Feed and Seed Sales company as a salesman. His office is in his home. He has a home computer and other office equipment which he uses for activities necessary to his employment as salesman.
The home computer and other office equipment are excluded resources.

NONBUSINESS PROPERTY EXCLUDED UP TO $6,000 EQUITY
Nonbusiness property that is used to produce goods or services essential to daily activities is an excluded resource up to $6,000 equity.

EXAMPLE 5:
Mrs. Gray owns an extra lot adjacent to her home. The market value of this lot is $7,000 and there is a city lien against it for $2,000. Equity value of the lot is $5,000. Mrs. Gray uses the lot for a garden.
The extra lot is an excluded resource because the equity value is less than $6,000 and it is used to produce goods for home consumption.

EXAMPLE 6:
Mrs. Mauve is buying two acres of pasture adjacent to her home with a market value of $8,000. She still owes $2,000 on the property so the equity value is $6,000. She uses the two acres of pasture to maintain livestock for food. She also has a tractor valued at $2,000 which is used to haul feed and water to the livestock.

The first $6,000 of equity value on the acreage and tractor is an excluded resource since they are used to produce goods for home consumption. $2,000 is a countable resource.

477-000-051 – Partnership/S-Corporation Income

MAGI S-Corporations and Partnership returns do not need to be reviewed by Central office as all business expenses are allowed per MAGI-based methodologies.

For Non-MAGI:

Schedule E

When a household's Federal Income Tax return (1040) shows income or a loss on Line 17, the amount shown will also be reflected on their Schedule E ("Supplemental Income and Loss"). The Schedule E will indicate the type(s) of supplemental income or losses being reported. Part I of the Schedule E shows "Income or Loss from Rental Real Estate and Royalties," and most expenses shown on Side 1, except for depreciation & depletion, are allowable.

Part II of the Schedule E, "Income or Loss from Partnerships and S Corporations," will indicate to the case manager if the household is involved in a Partnership or an "S" Corporation. If there is an entry in Part II of the Schedule E, the case manager must request additional tax documents from the household.

Partnerships

If Part II of the Schedule E shows a "P" in the area designated "Enter "P" for partnership; "S" for S Corporation," the household is involved in a Partnership. This means that the case manager will need to request certain IRS documents which are related to the status and income of the Partnership. The following IRS documents will be needed in order to determine the countable Partnership income:

* IRS Form 1065 – "U.S. Partnership Return of Income" – usually four pages in length, however, the "balance sheet" may not be included if it is not used;
* Schedule K-1 (Form 1065) – "Partner's Share of Income, Credits, Deductions, etc." – two pages in length, but sometimes the second page is not completed;
* (As Appropriate) – If the Partnership is involved in a farming operation, the Partnership must file a Schedule F.

Each partner in the Partnership should either have or be able to obtain a copy of the Partnership return and appropriate schedules.

"S" Corporations

If Part II of the Schedule E shows an "S" in the area designated "Enter "P" for partnership; "S" for S corporation," the household is involved in an "S" Corporation. An "S" Corporation is a pass-thru small business. All income and expenses pass thru to the individual shareholders by their percentage of ownership. The following IRS documents will be needed in order to determine the countable "S" Corporation income:

* IRS Form 1120S – "U.S. Income Tax Return for an S Corporation" – four pages in length;
* Schedule K-1 (Form 1120S) – "Shareholder's Share of Income, Deductions, Credits, etc." – two pages in length;
* (As Appropriate) – If the "S" Corporation is involved in a farming operation, the corporation must file a Schedule F.

Each shareholder of an "S" Corporation should either have or be able to obtain a copy of the 1120S, their Schedule K-1, and other corporate schedules as appropriate.

Other information

Part II of the Schedule E will also show if the involvement in the Partnership or "S" Corporation is passive or nonpassive. If the involvement is passive, the income is treated as unearned income. If the involvement is nonpassive, the income is treated as earned.

If a household member is an employee of a regular, or "C" Corporation, s/he will receive a W-2; income from this source is reported on Line 7 of their 1040 and is treated as regular wages. A copy of the Corporate tax return, IRS Form 1120, is not required, only verification of the income received from the Corporation.

As a general rule, the more documentation that is initially provided, the more promptly a determination of countable income can be made. When submitting documents to Medicaid Long-Term Care Policy for a determination of countable income, please include the household's 1040, any schedules (such as the Schedule A, Schedule E, Schedule F, etc.) accompanying the household's tax return.

477-000-052 – Business and Farm Equipment

Farm Equipment:
If it is necessary to determine the equity in farm equipment, the tax assessor's records may be used or consult a farm equipment dealer to arrive at a market value. Any loans, liens, etc. must be verified to determine equity.

Business Equipment, Fixtures, Machinery:
If it is necessary to determine the value of these resources, the owner's estimate of the current market price for the equipment, fixtures, or machinery may be used. If the client is unable to provide an estimate or if the agency feels the estimate is inaccurate, other sources may be used, such as an auctioneer, county assessor, etc.

Livestock, Poultry, Crops (Growing and On-Hand)
If it is necessary to determine the value of these resources, the owner's estimate of the current market price for livestock, poultry, and crops (growing and harvested) may be used. If the client is unable to provide an estimate or if the agency feels the estimate is inaccurate, other sources may be consulted such as an auctioneer, county assessor, etc.

477-000-058 – Examples: Considered Health Insurance

The following examples ARE considered health insurance. These policies provide or require specific medical or health service. Data should be entered on N-FOCUS/TPL and premium deductions allowed

Example 1:
Physicians Mutual Insurance; hospital daily indemnity policy; monthly premium of $15; pays $25 per day for every day hospitalized.

Example 2:
Amex Life Insurance; nursing home confinement policy; monthly premium of $52.20; pays $20 per day for every day of nursing home confinement for a maximum of twenty-four months.

Example 3:
Bankers Life and Casualty Co.; cancer treatment policy; monthly premium of $5.60; pays for cancer surgery and chemotherapy.

NOTE: (add manual ref. See 477 NAC 12-006 or 477 NAC 12-007 and 477 NAC 20-006.11) for treatment of Third Party Medical Payments received directly.

477-000-059 – Examples: Not Considered Health Insurance

The following examples are NOT considered health insurance. These are income replacement or accident policies and should NOT be entered on N-FOCUS/TPL. These policies can NOT be allowed as a medical deduction on a medical budget.

Example 4: GEM (University of Nebraska); school accident policy; pays for accidents related to school activities.

Example 5: Combined Insurance Co of America; accidental dismemberment policy; pays $5,000 for loss of any limb.

Example 6: Bankers Life and Casualty; accidental injury policy; pays $50 per day for any day unable to work due to injury while riding any public conveyance.

Example 7: Physicians Mutual Insurance; disability policy; pays $50 per day for any day of disability.

477-000-061 – Voter Registration Requirements

With the passage of the National Voter Registration Act and LB 76 in the State Legislature, the Nebraska Department of Health and Human Services (DHHS) through our local offices is required to offer individuals the opportunity to register to vote when they contact a local DHHS office. We will also routinely offer this opportunity to clients when they apply for or have an eligibility review of their case.

I. When an individual contacts DHHS and requests to register to vote but does not request or apply for services, staff will offer the individual the voter registration form. The individual may complete and -
   1. Return the signed voter registration form to DHHS for mailing; or
   2. Mail or take the voter registration form himself/herself to the county clerk or election commissioner in the county where s/he lives.

II. Individuals in households applying for services are offered the opportunity to register to vote each time they complete or update an application for assistance.

When the client indicates on the application that s/he wishes to register to vote –

1. DHHS shall give the individual the voter registration form. If more than one individual listed on the application is a potential voter, the worker shall provide as many forms as are needed or requested by the household.

2. DHHS shall explain that the signed voter registration forms may be -
   a. Returned to DHHS for mailing; or
   b. Mailed or taken directly to the county clerk or election commissioner in the county where the voter lives.

3. If the individual requests help in completing the form, staff may assist to the extent that assistance is given on completing the DHHS application. If the individual cannot read and requests assistance, staff will ask all the questions on the voter registration form, but will not probe if the person does not answer a question. Staff must NOT in any way influence the individual in completing the voter registration form.

4. If the signed voter registration form is returned to DHHS for mailing, staff shall forward it to the appropriate county clerk or election commissioner with the next mailing. DHHS is not responsible for the form being complete or the accuracy of the information on the form.

When the client answers the question on the application "No" or does not answer the question, s/he is considered to have declined the opportunity to register to vote at that time. The worker is not required to take any further action. The signing and dating of the application by the client will verify that the applicant has been given the opportunity to register to vote and has declined.

Staff will -

1. Send the signed voter registration forms received to the county clerk or election commissioner in the county where the individual(s) lives;
2. Order forms from the Central Office Mailroom as needed to ensure that an ample supply is available for individuals wishing to register;
3. Make the voter registration form available to individuals requesting to register, but not wishing to apply for services;

4. Explain the options available to return the signed registration form to DHHS for mailing or mail or take the form themselves to the county clerk or election commissioner in the county where they live.